JOINING FORCES

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IN THIS ISSUE

In this issue, Susan Kheder, MSW and Terry VandenBosch, MS, RN, CS, St. Joseph Mercy Health System, Ann Arbor, Michigan, describe how they assisted their hospital system in the establishment of a screening program for victims of domestic violence. Their program focused on training, policy development, and the measurement of outcomes. We are grateful for their willingness to share their work with our readers.

To augment Kheder and VandenBosch's work, we have reviewed three articles that address the topic of screening for domestic violence. These articles can be useful when considering the implementation of screening procedures. We also feature an article that describes the gap that often exists between research and couple or family therapy.

LTC Daniel McFerran is the new HQDA Family Advocacy Program Manager. On page 5, we provide a short description of some of his background and experiences.

INTIMATE PARTNER VIOLENCE: A HEALTH SYSTEM'S RESPONSE

Susan Kheder, MSW, ACSW
Terry VandenBosch, MS, RN, CS

Background

Intimate partner violence (IPV) is increasingly recognized as an important public health problem with major health consequences. Obviously, the most severe health consequence of IPV is homicide, which each year accounts for more than one-half of the homicides of women in the United States (Fagan & Browne, 1994). The physical sequelae of violence include pain, broken bones, facial trauma, irritable bowel syndrome, stress-related symptoms, and neurological problems. Depression, anxiety, and suicide attempts are also consequences of IPV.

Children in IPV situations are also profoundly affected. Between 40% to 70% of children entering battered women's shelters with their mothers, report abuse by the woman's intimate partner. Symptoms similar to post-traumatic stress disorder (PTSD) are often seen in these children (Kerouac, Taggart, Lescop & Fortin, 1986). IPV is also costly to health care systems in terms of the use of resources. In one study in an HMO setting, battered women and their children used health services six to eight times more often than control patients (Rath, Jaratt & Leonardson, 1989).

Screening for IVP

Universal screening by health care professionals can help identify IPV and usually patients do not object to screening questions. In one study, 78% of 164 primary care patients stated that they favored their physician's use of screening questions for physical abuse (Friedman, Samet & Roberts, 1992). While screening is an important method of identifying IPV, routine screening may be difficult to implement. Many health care providers resist the use of routine screening and administrative support is often needed to achieve and maintain its use (Campbell, et al., 1999). The literature reports that health care providers often focus on a victim's physical symptoms, distance themselves from victims, and may subtly blame the victim. A majority of providers appear uninterested, uncaring or uncomfortable with domestic violence situations (Gerbert, et al., 1996).

Our Screening Policy

In 1996, the Quality Council at St. Joseph Mercy Health System, a 799 licensed bed, 3 hospital health system in Michigan, charged a task force to address the issue of IVP. The following outcomes

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were expected: 1) To develop and implement a multidisciplinary hospital policy, 2) To develop and implement an education plan, 3) To provide support for hospital associates, 4) To measure process and outcome indicators. All of the outcomes were achieved.

Our screening policy for victims of IPV promotes the practice of screening women 16 years of age or over for the consequences of domestic and/or dating violence. While the policy primarily focuses on female victims, it also provides guidance for the identification of male victims of IPV.

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Screening is part of an initial assessment or intake history for all women, especially when abuse is suspected. Two research-based screening questions were standardized and added to verbal and self-assessment tools (Helton, McFarlane, & Anderson, 1987). Patients were asked the following questions: 1) In the past year, have you been hit, slapped, kicked, choked or otherwise physically hurt by someone? 2) Within the last year, have you been forced to have sexual contact when you did not want it?

The most significant outcome has been the development of less resistance towards screening for domestic violence by physicians. At first, many barriers existed and physicians, in particular, voiced several concerns. Some expressed beliefs such as IPV is between two people and is none of my business or IPV is a social issue not a health care issue.

Educating the task force and the hospital community was critical in dispelling myths and increasing the understanding of and knowledge about abusive relationships. Clarity about the nature of power and control that assailants often hold over abuse victims fostered the development of insight into the identification and management of IPV. In addition, an understanding of the physical sequelae of violence and its far-reaching effects upon children, the health care system, the workplace, and health care dollars were critical to a successful implementation of the policy.

As the policy began, physician departments were provided with one hour of training. Other departments received up to eight hours of training. A physician, a local domestic violence shelter leader, and an administrative staff person associated with the task force conducted the training. During the training, the policy and the dynamics of IPV were reviewed. Internal and local community resources were identified, and a specially designed physician's pocket guide on IPV was distributed. The training was well received and some departments requested additional training.

Measurement/Evaluation

Measurement throughout implementation of the education plan and screening policy was critical to determine practice patterns and compliance with the policy. One year after implementation of the policy, a 41-item survey was developed and administered to evaluate the staff's response to the organization's IPV initiatives. The survey measured health care providers' screening practices, beliefs and attitudes, system barriers, and training needs relative to IPV. The survey was administered to a 50% random sample of 1,000 staff physicians, nurses, social workers and other clinical mental health specialists in the health care system. A response rate of 51% (n=509) was achieved. Data from the survey provided a rich source of information about health care providers' perceptions and management of IPV.

For example, survey results from 132 physicians revealed the following:

- 56% agreed that time constraints make it difficult to screen for IPV

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- 55% agreed that different cultural beliefs/values make it difficult to discuss IPV with patients
- 73% disagreed that the screening questions seemed offensive or inappropriate
- 80% agreed that they felt comfortable asking female patients the IPV screening questions
- 28% agreed that they were not sure where to get help for patients
- 78% agreed that resources were sufficient to get the needed help
- 100% disagreed with the statement that " IPV is between two people and is not my business"
- 75% indicated that they had as much responsibility for dealing with IPV as with other health care problems

The physicians identified a need for additional training in the following areas: 1) legal issues, restraining orders, and professional liability, 2) referral options, 3) clinical indicators of IVP, 4) screening/assessment skills, and 5) cultural beliefs related to IVP.

Secondary analysis of survey data revealed a statistically significant relationship between several variables and provider screening practices. These findings led to a focused improvement plan to increase the screening for IPV that may be generalized to other settings. We are targeting our emergency services department for the first wave of focused educational efforts and expect practice changes that include universal screening.

Lessons Learned

Policy compliance varied by practice setting. Not every department was consistent in the implementation of universal screening. One lesson we learned is that it is important to conduct training and to begin the training process early. In hindsight, beginning the training with prevalence data and the dynamics of domestic violence may have lessened some of the initial resistance. Survey results indicated that once the education and policy implementation occurred, initial concerns were greatly reduced.

It is clear that the issue of domestic violence requires ongoing discussion, education, and creative strategies to help health care practitioners become more comfortable addressing IPV by using proactive screening procedures. As health care providers, it is our responsibility to acknowledge that IPV frequently occurs and to take an active role in identifying victims and preventing injuries or even death. Screening is a process by which we can live up to that responsibility and break the silence that surrounds the crime of intimate partner violence.

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Screening for Domestic Violence

Screening individuals and families for spouse and child abuse is a popular topic in the Army Family Advocacy Program. We review three articles about screening procedures. The first is a traditional approach to identifying female victims of violence through their own self-reports. The second attempts to identify female victims of violence, but through the reports of men who are clinic patients. The third article describes an educational program designed to increase the inquiries of medical residents about domestic violence among their patients.

1) A study of female victims estimated the prevalence of domestic violence (DV) in an emergency department in Denver, Colorado (Abbott, et al., 1995). Of 833 women who presented during 30 randomly selected 4-hour time blocks, 648 (78% response rate) agreed to participate in the study. Most participants were young (median age 34 years), unemployed (62%), and half had annual incomes less than $10,000. Of women with a current male partner, the incidence of DV was 11.7%. The lifetime prevalence of DV was 54.2%. Less than one quarter of the women who had experienced prior DV, presented to the emergency room for the care of trauma. Only 6 either told the staff about DV or were asked about it by the DV staff. Women exposed to acute or prior DV were more likely than those without DV to have made more suicide attempts and to report excessive alcohol use. It was concluded that the lifetime prevalence of DV was strikingly high and that women who have experienced DV are seldom identified by emergency department personnel.

Abbott, J., Johnson, R., Koziol-McLain, J., Lowenstein, S.R. (1995). Domestic violence against women: Incidence and prevalence in an emergency department population. Journal of the American Medical Association, 273, 1763-1767.

2) Little attention has been given to screening men for violence toward their female partners. Most of the screening research has questioned women about whether they have been the recipients of domestic violence.

Oriel and Fleming (1998) assessed whether men would answer questions about partner violence (PV) in a health care setting, estimated the prevalence of PV by male primary care patients, and identified characteristics associated with their violent behavior. A total of 375 men were seen during the study: 317 participated (85% response rate) and 237 met their inclusion criteria. Thirty-two men (13.5%) disclosed physical violence toward their partner in the past year and 10 (4.2%) reported severe violence. Men with a history of increased alcohol consumption, depression, or a history of childhood abuse were more likely to report that they had been violent. Analyses of men with all three of these variables resulted in a violence probability of 41% compared with a baseline probability of 7% if no risk factors were present. The authors concluded that physicians should consider screening male patients for their involvement in PV, especially when the men are depressed, heavy alcohol users, or were victims of childhood abuse.

Oriel, K.A. & Fleming, M.F. (1998). Screening men for partner violence in a primary care setting. Journal of Family Practice, 46, 493-498.

3) Family advocacy personnel can provide valuable information to staff physicians and residents on screening procedures. Knight and Remington (2000) assessed the effectiveness of an educational intervention to increase domestic violence (DV) screening by internal medicine residents.

Using a quasi-experimental pre-post design, the intervention consisted of a one session program with a mixture of topics and role-plays. The topics for the sessions with physicians were: prevalence of DV, important concepts in understanding DV such as power and control issues, survivors' stories, the role of healthcare providers, and familiarity with local resources. A discussion was also conducted about barriers to asking about DV. Three screening questions were suggested for use. The questions asked (1) whether the patient had been hit, kicked, punched or otherwise hurt during the past year, (2) about feelings of safety in the current relationship, and (3)whether there is a partner from a previous relationship that makes the patient feel unsafe.

Physicians were questioned about demographics and their attitudes and beliefs related to DV.

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Patients were questioned about demographics and if they had been asked about DV during the current visit. Prior to the intervention, 0.8% of patients reported being asked about DV; after the intervention, the percentage rose to 17%.

Knight, R.A. & Remington, P.L. (2000). Training internal medicine residents to screen for domestic violence. Journal of Women's Health and Gender-Based Medicine, 9(2), 167-174.

Much of the research on DV screening in the civilian community is directed toward the detection of violence that would be categorized as major violence. Often, such violence would be called "battering." While battering and major violence does exist in the military community, it is important to point out that even lower levels of violence can have serious consequences for spouses and children. Therefore, screening efforts can be targeted towards the identification of lower levels of DV. It is likely that significant therapeutic help can be provided for couples engaging in such violence.

LTC Daniel F. McFerran New HQDA Family Advocacy Program Manager

LTC Daniel F. McFerran is the new HQDA Family Advocacy Program Manager at the Community and Family Support Center. He assumed his current position in June 2000. In 1992, LTC McFerran was assigned to the Office of Family Policy, Office of the Deputy Assistant Secretary of Defense for Personnel Support, Families and Education as the Family Advocacy Officer. He assisted with policy development and overall management of Family Advocacy. Before leaving that assignment, LTC McFerran became the Associate Director of the Office of Family Policy.

LTC McFerran received a direct commission as a social work officer in the U.S. Army Reserve in 1981. He came on active duty in 1983 after receiving a MSW from the University of Maryland and a MBA from Western New England College. He has had a variety of assignments including Fort Bragg, Fort Stewart, and Korea. In these assignments he was responsible for a full range of social work services for soldiers and their families. His most recent assignments were at Walter Reed Army Medical Center as a fellow in the Social Work Fellowship in Child and Family Practice, Assistant Chief, Department of Social Work, and Chief of Care Continuum Management. LTC McFerran's telephone number is (703) 681-7393. His E-mail address is: Daniel.McFerran@CFSC.Army.Mil

Impact of Research on Couple and Family Therapy

In previous editions of Joining Forces we have featured an article that discussed statistical computations. Instead of statistics, we are addressing the impact of research on the clinical practice of couple and family therapy (CFT).

Relative to treatment interventions, FAP has emphasized the importance of outcome research, particularly with regard to whether various treatment modalities for family violence actually work. In this article, we review a paper by Pinsof and Wynne (2000) on their conceptualization of the relationship between research and clinical practice. Their thesis is that CFT research, as currently conducted, has had little impact on real life clinical practice because couple and family therapists do not consistently adhere to the rigid methodological demands called for in treatment-focused research. Generally, researchers are trained to use pre-set criteria, treatment manuals, and their work under controlled conditions with clients is usually monitored. On the other hand, clinicians are inclined to use eclectic, integrative, or multimodel methods of treatment based upon their perception of their clients' needs.

Often, there is a sense among therapists of needing a treatment model that works based upon clinical trials and scientific evidence. The question of whether the therapy works is called

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efficacy research. Efficacy research involves six primary elements: (1) a clinical laboratory setting; (2) a focus on a definable disorder or condition; (3) the presence of a treatment group and a control group; (4) the random assignment of clients to one of these two groups; (5) manualized treatment (i.e., therapy that is conducted using a standardized technique that is described in a manual on which the therapist is trained to a criterion) that is monitored during the therapy; and (6) pre-post therapy measures of some aspect of client functioning such as feelings and behaviors. Basically, efficacy research asks whether treatment is better than no treatment at all or whether one method of treatment is better than another.

Almost all the reviews with which we are familiar indicate that psychotherapy is generally thought to be better than no therapy. Some therapies have been shown to be better than others, and some studies indicate that a combination of therapies (e.g., medication and cognitive-behavior therapy for some forms of depression) are better than either type of singly applied treatment.

Effectiveness research follows the establishment of efficacy. It attempts to determine if the treatment that was found to be effective in a laboratory setting actually works in real-life practice. Such research would still be somewhat removed from practice because of its reliance upon a uniform concept of treatment, i.e., that the therapy was uniformly applied by all therapists and in all cases. Pinsoff and Wynne support a definition of effectiveness research that differs in two ways from that just described: it does not have to invariably follow efficacy research (because it may be impossible or impractical to conduct such treatment with certain populations) and it does not necessarily have to be based on manualized treatments. This second condition makes this form of effectiveness research less radically different from the way clinicians actually practice.

Pinsof and Wynne believe that what is needed in CFT research is a study of three elements: (1) how family change occurs naturalistically, (2) how families change in therapy, and (3) how to develop strategies to identify therapist interventions and in-therapy experiences that can be linked to client change.

How is the information in this article relevant to the Army FAP? The article questions the argument for standardized training and practice interventions and supports therapists' use of practice experience. This experience would be put to use in being observant on what actions make a difference to couples and families in and outside of therapy and what cues the therapist uses to guide the therapeutic process. Pinsof and Wynne describe therapy as essentially an ideographic process – one that is organized in regard to the individual and is based on a continual change of course in response to the cues provided by the client. Therapy is also seen as an educational activity, in which the therapist encourages clients to think, feel, or act differently in regard to themselves and others.

Pinsof and Wynne present a research model that they believe is clinically relevant and can change and inform treatment. As an alternative to treatment-focused efficacy and effectiveness research, Pinsof and Wynne propose the use of a client-focused learning process research model. They believe that this model will generate information to assist therapist in determining and influencing the progress of cases in the change process.

Pinsof, WM & Wynn LC (2000). Toward progress research: Closing the gap between family therapy practice and research. Journal of Marital and Family Therapy, 26, 108.

There are many possible approaches to conceptualizing and designing research that will contribute to your understanding of how to help FAP clients. We encourage you to consider the work of Pinsof and Wynne for an explanation of the relationship between research and real life clinical practice with FAP clients.

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